Commonwealth of Massachusetts
Group Insurance Commission

Vision Care Plan
Provided By

DAVIS VISION™
THE EYECARE ADVANTAGE
www.davisvision.com

Benefits Effective July 1, 2004

Dear Group Insurance Commission Vision Care Member:

Davis Vision is pleased to provide vision care products and services to you and your eligible dependents. Davis Vision is an award winning national vision care organization dedicated to 100% customer satisfaction and pledges that level of satisfaction to you and your family. Davis Vision has been providing quality products and services to the New England area for 40 years, (our first Massachusetts client in 1964 is still with us).

As a GIC member, you will be eligible to receive benefits from an extensive network of participating providers. To access benefits, simply call a participating provider of your choice from the list provided and give your ID number. The provider will obtain all necessary authorizations. There are no forms to complete when receiving services in network. Member services are available via the internet at www.davisvision.com where you can find a doctor, check your benefits and eligibility, or complete a Patient Satisfaction Survey. Or call toll-free 1-800-650-2466.

We are delighted to have the opportunity to provide GIC's vision care benefits.

Sincerely,

Carl Moroff, OD
Executive Vice President
Chief Operating Officer

Member Services

GIC members may conveniently access an array of information via Davis Vision's website at www.davisvision.com or accessing the Interactive Voice Response (IVR) unit by dialing 1-800-650-2466. Either system enables you to:

- Locate a nearby provider
- Review Benefit information
- Verify eligibility for you or your family members
- Ask questions about vision care services or providers
- Review your rights as a patient
- Complete (website) or request (IVR) a Patient Satisfaction Survey
- Request an Out-of-Network reimbursement claim form
- Obtain information regarding Laser Vision Correction
- Participants who use a Teletypewriter (TDD/TTY) because of hearing or speech disability may access TDD/TTY services by calling 1-800-523-2847
- Speak to a Member Service Representative (MSR), MSR's are available 8:00 AM - 8:00 PM, ET, Monday - Friday and 9:00 AM - 4:00 PM, ET, Saturday

Please contact your Group Insurance Coordinator directly if:

- You change your address
- You need a Student Verification Form

Benefit Eligibility

The Group Insurance Commission Vision Plan provides benefits to eligible state employees as described below.

Coverage for new employees will begin on the first day of the month following 60 days of employment or two calendar months, whichever is less. Employees who choose not to join the plan when first eligible must wait until the next annual enrollment period to elect coverage effective the following July 1. Eligible employees must work regularly at least 18.75 or 20 hours per week, depending on their agency's definition of "half-time".

You are eligible if:

- you work for the Commonwealth and are eligible for life and/or health insurance coverage provided by the GIC, and
- you are not otherwise eligible for vision care benefits pursuant to a separate appropriation; or
- you are not eligible for vision care benefits provided through the provisions of a contract; or
- you are not eligible for vision care benefits provided through the provisions of a collective bargaining agreement; or
- you are not eligible for vision care benefits provided in whole or in part through employer-provided funding.

You are not eligible if:

- you are employed by an Authority

Signing Up For Benefits

Eligible employees must submit a dental and vision enrollment form to the Group Insurance Commission in order to participate in the plan and enjoy the benefits. The GIC requires a list of your dependents and their birth dates and GIC ID numbers, (usually social security numbers), your current address and your GIC ID number (usually your social security number), and your signature authorizing the GIC to deduct your premium payment for vision care coverage. See your GIC Coordinator at your work site for an enrollment form.

While employees may voluntarily withdraw from the plan at any time during the year, those who do so will be ineligible for re-enrollment in the plan until the July 1st following 24 months from the date coverage ended.

If coverage is terminated or canceled for non-payment of premium, you will be ineligible for re-enrollment in the plan until the July 1st following 24 months from the date coverage ended.

FAMILY ELIGIBILITY

Family coverage under this plan includes employee's legal spouse, all unmarried dependent children up to 19 years of age and children of eligible unmarried dependents. In some cases, divorced spouses may also be eligible for coverage. All family members are eligible for the same levels of benefits.

Generally, coverage for children ends on the last day of the month in which the child reaches age 19. Exceptions to the rule are as follows:

- Married children are not eligible.
- Full-time students whose applications have been approved by the GIC are eligible. Eligible students age 24 and over must pay the full cost of the monthly premium. Unless the student is also enrolled in a health plan sponsored by the GIC, you must confirm your child's full-time student status each semester that your child is enrolled as a full-time student. This student verification form must be submitted directly to the GIC. See your GIC Coordinator for a student verification form. Failure to submit the required verification will result in denial of your student dependent's claims.
- Handicapped dependents whose applications have been approved by the GIC are eligible. Contact the GIC for a handicapped dependent application form.

Where a husband and wife are employed by the Commonwealth and both are eligible for coverage in the GIC Vision Plan, they may each have individual coverage or, alternatively, one may have family coverage that will cover the other as a dependent. If you have a question about eligibility for you or your dependents, please call the GIC at (617) 727-2310. Participants who use a Teletypewriter (TDD/TTY) because of hearing or speech disability may access TDD/TTY services by calling 1-617-227-8583.

COST OF BENEFITS

To receive vision care benefits under this plan, you are required to pay a monthly premium. The premium payment will cover a single unified plan of dental and vision care benefits. Some vision care services will require a member co-payment. Contact your GIC Coordinator for current premium rates.

TERMINATION OF BENEFITS

Benefits under the vision plan end on the last day of the month in which you cease to be an eligible employee as defined above. Benefits will also end if you fail to pay the applicable premium.

CONTINUATION OF BENEFITS

COBRA Continuation Coverage

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group dental/vision coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's dental/vision benefits program, you have the right to choose COBRA coverage if:

- You lose your group dental/vision coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's dental/vision benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC dental/vision coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse divorce or legally separate.

If you have dependent children who are covered by the GIC's dental/vision benefits program, each child has the right to elect COBRA coverage if he or she loses GIC dental/vision coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced;
- The parents divorce or legally separate; or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full time student or ceases to be a full-time student).

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group dental/vision coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event - the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage.** Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid in full when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group dental/vision plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group dental/vision coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**
Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make each monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group dental/vision benefits coverage will end and you will lose all rights

to COBRA coverage.

- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make the payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced;
- The employee or former employee dies;
- The employee divorces or legally separates;
- The employee or employee's former spouse remarries;
- A covered child ceases to be a dependent;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Your Vision Plan

The GIC Vision Plan provides members with the maximum choice for benefits including the Participating Provider Network and Out-of-Network reimbursement. Accessing benefits through the Participating Provider Network maximizes your benefit with a “paid in full” option for eye examinations and eyewear. However, you may decide which option is best for you at the time that you actually use the benefit.

Eligible beneficiaries age 19 through age 60 may receive vision benefits once every 24 months. Beneficiaries age 18 or under and age 61 or over may receive vision benefits once every 12 months.

PARTICIPATING PROVIDERS

Participating providers are licensed providers who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please visit the Davis Vision website at www.davisvision.com (“Find A Doctor” feature) or call toll free 1-800-650-2466 to obtain a list of participating providers, including address and phone number, in your area.

Receiving Services

To receive vision care services simply:

- Call the participating provider of your choice and schedule an appointment
- Identify yourself as a Commonwealth of Massachusetts Group Insurance Commission member or covered dependent
- Provide the office with the member’s ID number and the year of birth of any covered children needing services

It’s that easy! The provider’s office will verify your eligibility for services and no claim forms are required.

Plan Benefits Available At No Cost

- Eye Examination (including dilation as professionally indicated)
- Plan covered frame from the Designer or Fashion collection (over 200 frames to choose from, many with retail values up to $125)
- Spectacle lenses in plastic or glass including single vision, bifocal or trifocal lenses, in any prescription range
- Glass grey #3 prescription sunglasses
- Oversize lenses
- Post cataract lenses
- Polycarbonate lenses (for dependent children or monocular patients)
- Fashion, sun or gradient tinted plastic lenses
- Medically necessary contact lenses (with prior approval)

OPTIONAL ITEMS WITH MEMBER COPAYMENT

ITEM	COPAYMENT
▪ Contact Lenses (most popular types of soft standard, replacement and disposable lenses available)	$50 or $70
▪ Premier frame from the "Collection" (with retail value up to $175)	$30
▪ Polycarbonate Lenses(for adults)	$30
▪ Ultraviolet coating	$12
▪ SuperShield® (scratch-resistant) coating	$20
▪ Blended Invisible Bifocals	$20
▪ Photogrey Extra® (sun-sensitive) glass lenses	
Single Vision	$15
Multifocal	$25
▪ Progressive Addition Lenses*	
Standard	$50
Premium	$80
▪ Glare Resistant Treatment	$35
▪ Transitions® (sun-sensitive) plastic lenses	$80
▪ High Index (thinner and lighter) lenses	$55
▪ Polaroid lenses	$60

**Progressive Addition multifocal lenses can be worn by most people. Conventional bifocals will be provided for anyone who is unable to adapt to progressive lenses, however, any copayment will not be refunded.*

PLAN ALLOWANCES

Should you choose a frame that is not available in the "Collection", you will be given a $38 retail credit towards the purchase. Should you require contact lenses not available through the plan (such as Toric or rigid gas permeable), you will be given a $100 retail credit towards the purchase of the contact lenses and the provider's professional fees.

ADDED FEATURES

Although not covered through your GIC benefits, you and your eligible family members can receive Laser Vision Correction services through a network of experienced, credentialed surgeons at significant discounts. Discounts up to 25% off Usual and Customary fees or 5% off any advertised special, whichever is less, are available through the program. For more information, or to find a participating provider, please visit the website at www.davisvision.com or call us at 1-800-650-2466.

Free membership and access to an exclusive mail order replacement contact lens service, LENS 1-2-3®, providing a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the website at www.lens123.com.

WARRANTY

All plan eyewear (frame and lenses completely provided through the Davis Vision laboratory) is covered with a two year unconditional breakage warranty.

OUT-OF-NETWORK BENEFITS

You may receive services from a non-participating provider, although you will receive the greatest value for your benefit dollar at a participating provider. When receiving services from a non-participating provider, you will be responsible for payment in full and submit a claim for reimbursement. You will be reimbursed in accordance with the following schedule:

ITEM	REIMBURSEMENT
Examination	$30
Frame	$38
Single Vision Lenses	$40
Bifocal Lenses	$50
Trifocal Lenses	$60
Contact Lenses	$100

Submit claims to: **Vision Care Processing Unit**
P.O. Box 1525
Latham, NY 12110

To request a claim form please call 1-800-650-2466 or download a claim form at **www.davisvision.com**.

LIMITATIONS AND EXCLUSIONS

If this booklet does not expressly provide for a vision benefit or service, such benefit or service is understood as not covered under this vision plan. In addition, the following limitations and exclusions apply:

- Benefits are not allowed on a more frequent basis than is described herein;
- Medical treatment of eye disease or injury (generally covered under medical);
- Non-prescription eyeglasses are not covered by the plan;
- Although you may receive services from both a participating and non-participating provider, it is suggested (for continuity of care) that all services be obtained from one provider at one time. Three parts of the vision care benefit (examination, lenses, frames) may not be split between a Preferred Vision Plan provider and an Out-of-Network vision provider;
- Contact lenses and eyeglasses during the same benefit period;
- No benefits will be paid under the plan for non-covered plan services or products, including vision therapy, nor will reimbursement be made for any vision services or supplies for which you or your dependents are not required to pay or charges that would not have been made if no coverage were available;
- Services will not be covered if not performed by a licensed eye care professional;
- Replacement of lost or stolen eyewear is not covered;
- Insurance for contact lenses is not covered.